SERFF Tracking Number:	*AMLC-126445851*	*State:*	*Arkansas*
Filing Company:	*Liberty National Life Insurance Company*	*State Tracking Number:*	*44500*
Company Tracking Number:	*R2520A*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Career Life Plus Application*		
Project Name/Number:	*Career Life Plus Application/R2520A*		

Filing at a Glance

Company: Liberty National Life Insurance Company

Product Name: Career Life Plus Application	SERFF Tr Num: AMLC-126445851	State: Arkansas
TOI: L07I Individual Life - Whole	SERFF Status: Closed-Approved-Closed	State Tr Num: 44500
Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life	Co Tr Num: R2520A	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Pattie Church, Donna Kennedy	Disposition Date: 01/14/2010
	Date Submitted: 01/07/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name: Career Life Plus Application
Project Number: R2520A
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 01/14/2010

Deemer Date:
Submitted By: Donna Kennedy
Filing Description:
RE: Form – R2520A – Career Life Plus Application

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 07/03/2008
Domicile Status Comments: This form was approved in Nebraska, our state of domicile, on 7/3/08.
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 01/14/2010
Created By: Donna Kennedy
Corresponding Filing Tracking Number:

Enclosed for your review and approval is a copy of the above referenced form. This form has updated replacement

SERFF Tracking Number:	*AMLC-126445851*	*State:*	*Arkansas*
Filing Company:	*Liberty National Life Insurance Company*	*State Tracking Number:*	*44500*
Company Tracking Number:	*R2520A*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Career Life Plus Application*		
Project Name/Number:	*Career Life Plus Application/R2520A*		

questions to reflect Arkansas adoption of the NAIC Model Replacement Regulation pursuant to Arkansas Regulation 97.

R2520A will replace Form R-2520-A, Ed. 2/98 which was approved by your department on October 30, 1997. The Flesch score for Form R-2520A is 53.

To the best of our knowledge and belief this form complies with the laws and regulations of your state. This form does not contain any language that is unusual in terms of normal company or industry standards.

Included with this filing are transmittal documents or other documents required by your State.

Should you require additional information or if you should have any questions, please do not hesitate to contact me at 1-800-288-2722, extension 4919 or by email at regulatory@libnat.com.

Company and Contact

Filing Contact Information

Pattie Church, Compliance Analyst	regulatory@libnat.com
2001 Third Avenue South	205-325-4919 [Phone]
Birmingham, AL 35233	205-325-2720 [FAX]

Filing Company Information

Liberty National Life Insurance Company	CoCode: 65331	State of Domicile: Nebraska
2001 Third Avenue South	Group Code: 290	Company Type: Life and Health
Birmingham, AL 35233	Group Name: Liberty National Life	State ID Number:
(800) 288-2722 ext. 2912[Phone]	FEIN Number: 63-0124600	

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	We are paying the required filing fee of $20 for a separate form.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Liberty National Life Insurance Company	$20.00	01/07/2010	33334929

SERFF Tracking Number:	*AMLC-126445851*	*State:*	*Arkansas*
Filing Company:	*Liberty National Life Insurance Company*	*State Tracking Number:*	*44500*
Company Tracking Number:	*R2520A*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Career Life Plus Application*		
Project Name/Number:	*Career Life Plus Application/R2520A*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/14/2010	01/14/2010

SERFF Tracking Number:	*AMLC-126445851*	*State:*	*Arkansas*
Filing Company:	*Liberty National Life Insurance Company*	*State Tracking Number:*	*44500*
Company Tracking Number:	*R2520A*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Career Life Plus Application*		
Project Name/Number:	*Career Life Plus Application/R2520A*		

Disposition

Disposition Date: 01/14/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMLC-126445851*	*State:*	*Arkansas*
Filing Company:	*Liberty National Life Insurance Company*	*State Tracking Number:*	*44500*
Company Tracking Number:	*R2520A*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Career Life Plus Application*		
Project Name/Number:	*Career Life Plus Application/R2520A*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Career Life Plus Application		Yes

SERFF Tracking Number:	*AMLC-126445851*	*State:*	*Arkansas*
Filing Company:	*Liberty National Life Insurance Company*	*State Tracking Number:*	*44500*
Company Tracking Number:	*R2520A*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Career Life Plus Application*		
Project Name/Number:	*Career Life Plus Application/R2520A*		

Form Schedule

Lead Form Number: R2520A

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	R2520A	Application/ Enrollment Form	Career Life Plus Application	Initial		53.000	R2520A.pdf

Arkansas ONLY

CAREER LIFE plus

20003201

Application to: **LIBERTY NATIONAL LIFE INSURANCE COMPANY**

Requested Effective Date: / /			
Branch	Agency	Agent Number	Client Number

PART 1 – EMPLOYEE INFORMATION

Employee Name First Middle Last

Social Security No.

MODE: ☐ BB (Attach Auth. & voided check) ☐ PD Franchise# _____ ☐ WD LNL Emp.# _____

Mailing Address Apt. #

Employer of Applicant

City State Zip

Employment Date ____ / ____ Month Year

Home Telephone Number ( )

Does the Proposed Insured have existing Life Insurance or Annuities inforce, including policies under conditional receipt, other than Group or Credit Life Insurance with this or any other company? **If "Yes," comply with the applicable Replacement Regulation or Rule.** ..... **Yes** ☐ **No** ☐

(a) Is the applicant/Employee presently at work on a full-time basis? ..... ☐ ☐ (a)

(b) Is Automatic Premium loan desired on all policies applied for? ..... ☐ ☐ (b)

(c) **A recorded interview may be necessary as part of the underwriting of this application.**
The most convenient time and place for the phone interview is:
☐ Home (Phone # from above will be used) Preferred Time ☐ 8AM - Noon ☐ 6PM - 9PM ☐ Noon - 6PM
☐ Office (Phone # _____) E-mail address: _____ @ _____

IF COVERAGE ON EMPLOYEE IS DESIRED, COMPLETE REMAINDER OF PART I AND PART III.

1. Sex ☐ M ☐ F | Date of Birth / / | Age Last Birthday | Height ft. in. | Weight lbs.

PLAN: ☐ With ADB and PW ☐ No ADB and PW | Premium $ | 1. ☐ Weekly 2. ☐ Bi-Weekly 3. ☐ Semi-Monthly 4. ☐ Monthly | Amount received with application $

(Include base premium plus extra benefits applied for.)

Beneficiary | Relationship | Age

PART II–DEPENDENT INFORMATION

(COMPLETE PART II & PART III FOR EACH DEPENDENT APPLYING FOR COVERAGE.)

2. Proposed Insured First Middle Last | Social Security No. | Relationship to employee

Sex ☐ M ☐ F | Date of Birth / / | Age Last Birthday | Height ft. in. | Weight lbs.

PLAN: ☐ With ADB and PW ☐ No ADB and PW | Premium $ | 1. ☐ Weekly 2. ☐ Bi-Weekly 3. ☐ Semi-Monthly 4. ☐ Monthly | Amount received with application $

(Include base premium plus extra benefits applied for.)

Beneficiary | Relationship | Age

3. Proposed Insured First Middle Last | Social Security No. | Relationship to employee

Sex ☐ M ☐ F | Date of Birth / / | Age Last Birthday | Height ft. in. | Weight lbs.

PLAN: ☐ With ADB and PW ☐ No ADB and PW | Premium $ | 1. ☐ Weekly 2. ☐ Bi-Weekly 3. ☐ Semi-Monthly 4. ☐ Monthly | Amount received with application $

(Include base premium plus extra benefits applied for.)

Beneficiary | Relationship | Age

4. Proposed Insured First Middle Last | Social Security No. | Relationship to employee

Sex ☐ M ☐ F | Date of Birth / / | Age Last Birthday | Height ft. in. | Weight lbs.

PLAN: ☐ With ADB and PW ☐ No ADB and PW | Premium $ | 1. ☐ Weekly 2. ☐ Bi-Weekly 3. ☐ Semi-Monthly 4. ☐ Monthly | Amount received with application $

(Include base premium plus extra benefits applied for.)

Beneficiary | Relationship | Age

R2520A 1009

RECEIPT (not to be detached unless premium collected)

We have received from _____ the sum of $_____ as a deposit on an application (detached herefrom and bearing the same date as this receipt) for a policy of life insurance. This payment is made and accepted subject to the conditions set out on the back of this receipt. **PLEASE READ THESE CONDITIONS CAREFULLY.**

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY.
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Branch No. _____ Agency No. _____ By _____ Agent

Dated at _____ , State of _____ , Date _____ , 20____ .

Unless you receive a policy or your money is refunded within 60 days from the date of this receipt, please notify the Company, (Liberty National Life, P.O. Box 2612, Birmingham, Alabama 35202) giving the amount paid, date of payment, and the name of the Agent shown above.

R2520A 1009

PART III – ANSWER QUESTIONS 1 THROUGH 7 ON ALL PROPOSED INSUREDS

	Yes	No	
1. Has any Proposed Insured lost more than 14 days from his or her regular duties during the past 60 days due to illness or injury?	☐	☐	1.
2. Has any application for insurance on any Proposed Insured been declined or postponed within the past 3 years?	☐	☐	2.
3. Has any Proposed Insured ever been diagnosed as having an immune deficiency disorder, AIDS, the AIDS-Related Complex (ARC) or tested positively for antibodies to the HIV virus?	☐	☐	3.
4. During the past (3) years, has any Proposed Insured:			
(a) Received or been recommended for treatment or counseling regarding the use of alcohol or drugs?	☐	☐	4a.
(b) Used heroin, cocaine or other similar agent or narcotic drug?	☐	☐	4b.
5. Is any Proposed Insured bedridden or confined to a hospital, nursing home or requiring regular institutional care?	☐	☐	5.

6. If any Proposed Insured has had surgery for, been treated for or been diagnosed as having any of the following, check "Yes" and check the applicable boxes:

	Yes	No	Within 3 Years	More than 3 but less than 8 Years	8 Years or More
(a) Heart attack, angina, congestive heart failure, coronary artery disease, heart enlargement or cardiomyopathy?	☐	☐	☐	☐	☐
(b) Stroke, emphysema, sickle cell anemia (not trait), kidney failure, chronic hepatitis or cirrhosis of the liver?	☐	☐	☐	☐	☐
(c) Cancer (other than skin), melanoma, Hodgkin's disease, leukemia or malignant tumor?	☐	☐	☐	☐	☐
(d) Epilepsy, seizure disorder, Down's Syndrome, Alzheimer's disease, mental retardation, amnesia, muscular dystrophy or multiple sclerosis?	☐	☐	☐	☐	☐

7. If any Proposed Insured has been diagnosed as having any of the following, check "Yes" and check the applicable boxes:

	Yes	No	Diabetes Diagnosed Within 10 Years	Diabetes Diagnosed More Than 10 Years Ago
(a) Diabetes but has no history of high blood pressure?	☐	☐	☐	☐
(b) Diabetes and also has a history of high blood pressure?	☐	☐	☐	☐

List below the number and name of any Proposed Insured for whom a "Yes" answer for any Questions 1 through 7 of Part III applies. List the number of the "Yes" question:

Proposed Insured Number	Proposed Insured Name	Question Number Answered "Yes"

I hereby declare that the statements recorded above are true and completed to the best of my knowledge and belief with respect to any Proposed Insured. I agree that: (1) the insurance on the applicant will become effective on the date of this application. If on the date of this application, the proposed dependent insured(s) is/are alive and whose health remains as stated in the application, then the insurance on such dependent will take effect on the date of application. Unless the Company has declined to issue the insurance applied for, the insurance will continue in force for sixty (60) days; (2) no agent has authority to accept risks or make or change contracts or waive the Company's rights or requirements; (3) only the information which the applicant has given in the application, or contained in the Company's records will be used to evaluate the eligibility for this insurance. This information will not be disclosed to any other company or person without written authorization; and (4) acceptance of a policy by the applicant will constitute ratification of any changes made by the Company under "Home Office Endorsement." I understand and agree that the Company reserves the right during the first year the policy is in force, to restrict beneficiaries to designations acceptable to the Company. Except with respect to a minor child of mine, this application is made with the knowledge and consent of the Proposed Insured. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated at _____ State of _____

This _____ day of _____ ,20_____

Witness _____

_____
Signature of Applicant

_____
Signature of Proposed Insured's Spouse
(if required in your state)

AGENT'S STATEMENT

To the best of my knowledge and belief, the insurance applied for ___is ___is not intended to replace any insurance now in effect. Is the Proposed Insured covered under one or more existing life insurance policies or annuities in force, including policies under conditional receipt, with any insurance company ___Yes ___No (follow all applicable state requirements.)

I certify that I have asked each adult Proposed Insured the questions contained in this application and have recorded the answers hereon. Each adult Proposed Insured has signed the application in my presence or lives at the same address as the applicant.

_____ _____
Print or Type Agent's Name Agent's Signature

R2520A 1009

If on the date of application the Proposed Insured(s) are alive and are risks acceptable to the Company under its rules, limits and standards for the plan applied for, then the insurance applied for will take effect on the date of the application. Unless the Company has declined to issue the insurance applied for, the insurance will continue in force until the earlier of: (a) the expiration of the period covered by the payments received for herein; or (b) the expiration of 60 days. If the application is accepted and a policy issued, this sum will be applied toward payment of the premium thereon. If the Company declines to issue any policy applied for, the amount of the application deposit for such policy will be returned to the applicant. No insurance will become effective unless the application to which this receipt is attached is received by the Company at its home office.

No agent has authority to accept risks or make or change contracts or waive the Company's rights or requirements.

This receipt is issued on the condition that any check, draft or other order for payment of money be good and collectable. This receipt is not transferable and will not be valid for any purpose if any erasures or alterations have been made in the printed form.

Only the information which the applicant has given in the answers to the questions on the application, or contained in the Company's records will be used to evaluate the eligibility for this insurance. This information will not be disclosed to any other company or person without written authorization.

SERFF Tracking Number:	*AMLC-126445851*	*State:*	*Arkansas*
Filing Company:	*Liberty National Life Insurance Company*	*State Tracking Number:*	*44500*
Company Tracking Number:	*R2520A*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Career Life Plus Application*		
Project Name/Number:	*Career Life Plus Application/R2520A*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

See Attached

Attachment:

AR Readability Certification.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

This form is being filed for approval.

Attachment:

R2520A.pdf

Item Status: **Status Date:**

Bypassed - Item: Life & Annuity - Acturial Memo

Bypass Reason: This is an application filing only not a policy filing.

Comments:

STATE OF ARKANSAS

READABILITY CERTIFICATION

FORM NO.	DESCRIPTION	SCORE	SCORED SEPARATELY
R2520A	Career Life Plus Application	53	X

This is to certify that the above listed forms have achieved the Flesch Ease Score indicated, and that to the best of my knowledge and belief comply with the requirements to **Ark. Stat.Ann.Sec. 66-3251** through **66.3258**, cited as the Life and Disability Insurance Policy Language Simplification Act.

Cathy C. Pilcher
Second Vice President, Compliance
United Investors Life Insurance Company

01/07/10
Date

P-123, Rev. 9/97

Arkansas ONLY

CAREER LIFE plus

20003201

Application to: **LIBERTY NATIONAL LIFE INSURANCE COMPANY**

Requested Effective Date: / /			
Branch	Agency	Agent Number	Client Number

PART 1 – EMPLOYEE INFORMATION

Employee Name First Middle Last

Social Security No.

MODE: ☐ BB (Attach Auth. & voided check) ☐ PD Franchise# _____ ☐ WD LNL Emp.# _____

Mailing Address Apt. #

Employer of Applicant

City State Zip

Employment Date ____ / ____ Month Year

Home Telephone Number ( )

Does the Proposed Insured have existing Life Insurance or Annuities inforce, including policies under conditional receipt, other than Group or Credit Life Insurance with this or any other company? **If "Yes," comply with the applicable Replacement Regulation or Rule.** ..... **Yes** ☐ **No** ☐

(a) Is the applicant/Employee presently at work on a full-time basis? ..... ☐ ☐ (a)

(b) Is Automatic Premium loan desired on all policies applied for? ..... ☐ ☐ (b)

(c) **A recorded interview may be necessary as part of the underwriting of this application.**
The most convenient time and place for the phone interview is:
☐ Home (Phone # from above will be used) Preferred Time ☐ 8AM - Noon ☐ 6PM - 9PM ☐ Noon - 6PM
☐ Office (Phone # _____) E-mail address: _____ @ _____

IF COVERAGE ON EMPLOYEE IS DESIRED, COMPLETE REMAINDER OF PART I AND PART III.

1. Sex ☐ M ☐ F | Date of Birth / / | Age Last Birthday | Height ft. in. | Weight lbs.

PLAN: ☐ With ADB and PW ☐ No ADB and PW | Premium $ | 1. ☐ Weekly 2. ☐ Bi-Weekly 3. ☐ Semi-Monthly 4. ☐ Monthly | Amount received with application $

(Include base premium plus extra benefits applied for.)

Beneficiary | Relationship | Age

PART II–DEPENDENT INFORMATION

(COMPLETE PART II & PART III FOR EACH DEPENDENT APPLYING FOR COVERAGE.)

2. Proposed Insured First Middle Last | Social Security No. | Relationship to employee

Sex ☐ M ☐ F | Date of Birth / / | Age Last Birthday | Height ft. in. | Weight lbs.

PLAN: ☐ With ADB and PW ☐ No ADB and PW | Premium $ | 1. ☐ Weekly 2. ☐ Bi-Weekly 3. ☐ Semi-Monthly 4. ☐ Monthly | Amount received with application $

(Include base premium plus extra benefits applied for.)

Beneficiary | Relationship | Age

3. Proposed Insured First Middle Last | Social Security No. | Relationship to employee

Sex ☐ M ☐ F | Date of Birth / / | Age Last Birthday | Height ft. in. | Weight lbs.

PLAN: ☐ With ADB and PW ☐ No ADB and PW | Premium $ | 1. ☐ Weekly 2. ☐ Bi-Weekly 3. ☐ Semi-Monthly 4. ☐ Monthly | Amount received with application $

(Include base premium plus extra benefits applied for.)

Beneficiary | Relationship | Age

4. Proposed Insured First Middle Last | Social Security No. | Relationship to employee

Sex ☐ M ☐ F | Date of Birth / / | Age Last Birthday | Height ft. in. | Weight lbs.

PLAN: ☐ With ADB and PW ☐ No ADB and PW | Premium $ | 1. ☐ Weekly 2. ☐ Bi-Weekly 3. ☐ Semi-Monthly 4. ☐ Monthly | Amount received with application $

(Include base premium plus extra benefits applied for.)

Beneficiary | Relationship | Age

R2520A 1009

RECEIPT (not to be detached unless premium collected)

We have received from _____ the sum of $_____ as a deposit on an application (detached herefrom and bearing the same date as this receipt) for a policy of life insurance. This payment is made and accepted subject to the conditions set out on the back of this receipt. **PLEASE READ THESE CONDITIONS CAREFULLY.**

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY.
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Branch No. _____ Agency No. _____ By _____ Agent

Dated at _____ , State of _____ , Date _____ , 20____ .

Unless you receive a policy or your money is refunded within 60 days from the date of this receipt, please notify the Company, (Liberty National Life, P.O. Box 2612, Birmingham, Alabama 35202) giving the amount paid, date of payment, and the name of the Agent shown above.

R2520A 1009

PART III – ANSWER QUESTIONS 1 THROUGH 7 ON ALL PROPOSED INSUREDS

	Yes	No	
1. Has any Proposed Insured lost more than 14 days from his or her regular duties during the past 60 days due to illness or injury?	☐	☐	1.
2. Has any application for insurance on any Proposed Insured been declined or postponed within the past 3 years?	☐	☐	2.
3. Has any Proposed Insured ever been diagnosed as having an immune deficiency disorder, AIDS, the AIDS-Related Complex (ARC) or tested positively for antibodies to the HIV virus?	☐	☐	3.
4. During the past (3) years, has any Proposed Insured:			
(a) Received or been recommended for treatment or counseling regarding the use of alcohol or drugs?	☐	☐	4a.
(b) Used heroin, cocaine or other similar agent or narcotic drug?	☐	☐	4b.
5. Is any Proposed Insured bedridden or confined to a hospital, nursing home or requiring regular institutional care?	☐	☐	5.

6. If any Proposed Insured has had surgery for, been treated for or been diagnosed as having any of the following, check "Yes" and check the applicable boxes:

	Yes	No	Within 3 Years	More than 3 but less than 8 Years	8 Years or More
(a) Heart attack, angina, congestive heart failure, coronary artery disease, heart enlargement or cardiomyopathy?	☐	☐	☐	☐	☐
(b) Stroke, emphysema, sickle cell anemia (not trait), kidney failure, chronic hepatitis or cirrhosis of the liver?	☐	☐	☐	☐	☐
(c) Cancer (other than skin), melanoma, Hodgkin's disease, leukemia or malignant tumor?	☐	☐	☐	☐	☐
(d) Epilepsy, seizure disorder, Down's Syndrome, Alzheimer's disease, mental retardation, amnesia, muscular dystrophy or multiple sclerosis?	☐	☐	☐	☐	☐

7. If any Proposed Insured has been diagnosed as having any of the following, check "Yes" and check the applicable boxes:

	Yes	No	Diabetes Diagnosed Within 10 Years	Diabetes Diagnosed More Than 10 Years Ago
(a) Diabetes but has no history of high blood pressure?	☐	☐	☐	☐
(b) Diabetes and also has a history of high blood pressure?	☐	☐	☐	☐

List below the number and name of any Proposed Insured for whom a "Yes" answer for any Questions 1 through 7 of Part III applies. List the number of the "Yes" question:

Proposed Insured Number	Proposed Insured Name	Question Number Answered "Yes"

I hereby declare that the statements recorded above are true and completed to the best of my knowledge and belief with respect to any Proposed Insured. I agree that: (1) the insurance on the applicant will become effective on the date of this application. If on the date of this application, the proposed dependent insured(s) is/are alive and whose health remains as stated in the application, then the insurance on such dependent will take effect on the date of application. Unless the Company has declined to issue the insurance applied for, the insurance will continue in force for sixty (60) days; (2) no agent has authority to accept risks or make or change contracts or waive the Company's rights or requirements; (3) only the information which the applicant has given in the application, or contained in the Company's records will be used to evaluate the eligibility for this insurance. This information will not be disclosed to any other company or person without written authorization; and (4) acceptance of a policy by the applicant will constitute ratification of any changes made by the Company under "Home Office Endorsement." I understand and agree that the Company reserves the right during the first year the policy is in force, to restrict beneficiaries to designations acceptable to the Company. Except with respect to a minor child of mine, this application is made with the knowledge and consent of the Proposed Insured. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated at _____ State of _____

This _____ day of _____ ,20_____

Witness _____

_____
Signature of Applicant

_____
Signature of Proposed Insured's Spouse
(if required in your state)

AGENT'S STATEMENT

To the best of my knowledge and belief, the insurance applied for ___is ___is not intended to replace any insurance now in effect. Is the Proposed Insured covered under one or more existing life insurance policies or annuities in force, including policies under conditional receipt, with any insurance company ___Yes ___No (follow all applicable state requirements.)

I certify that I have asked each adult Proposed Insured the questions contained in this application and have recorded the answers hereon. Each adult Proposed Insured has signed the application in my presence or lives at the same address as the applicant.

_____ _____
Print or Type Agent's Name Agent's Signature

R2520A 1009

If on the date of application the Proposed Insured(s) are alive and are risks acceptable to the Company under its rules, limits and standards for the plan applied for, then the insurance applied for will take effect on the date of the application. Unless the Company has declined to issue the insurance applied for, the insurance will continue in force until the earlier of: (a) the expiration of the period covered by the payments received for herein; or (b) the expiration of 60 days. If the application is accepted and a policy issued, this sum will be applied toward payment of the premium thereon. If the Company declines to issue any policy applied for, the amount of the application deposit for such policy will be returned to the applicant. No insurance will become effective unless the application to which this receipt is attached is received by the Company at its home office.

No agent has authority to accept risks or make or change contracts or waive the Company's rights or requirements.

This receipt is issued on the condition that any check, draft or other order for payment of money be good and collectable. This receipt is not transferable and will not be valid for any purpose if any erasures or alterations have been made in the printed form.

Only the information which the applicant has given in the answers to the questions on the application, or contained in the Company's records will be used to evaluate the eligibility for this insurance. This information will not be disclosed to any other company or person without written authorization.